ENT & Allergy
ASSOCIATES, S.C.

Authorization for Disclosure of Protected Health Information

EAR, NOSE & THROAT | ALLERGY & ASTHMA | HEARING CENTER

Patient Name: Date of Birth:

Address:

I authorize this use and/or disclosure of my protected health information:

From:

ENT & Allergy Associates
512 S 28th Ave
Wausau, WI 54401

To:

Name:

Organization:

Address:

City: State: Zip:

Phone:

Fax:

Information to be disclosed includes:

Please provide specific dates or occurrences that will specifically identify the information you are requesting:

Disclosure: I understand that, if the persons or organizations I am authorizing to receive and/or use the protected health information are not subjected to federal health information privacy laws, they may further disclose the protected health information and I may no longer be protected by federal health information privacy laws. I understand I have the right to revoke or review the disclosure/ materials at any given time. A copy of this authorization is as valid as the original.

Signature of Patient: **Date:**

If request is made by another legally authorized person, please state relationship/legal authority enabling you to act on behalf of the subject individual:

Relationship:

Signature: Date:

Processed By: Date: